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Journal of School Health

THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction.
Your participation by membership is solicited.

Vol. XXI DECEMBER, 1951 No. 10

SCHOOL CARDIAC SERVICES

JACOB M. CAHAN, M.D.
Philadelphia, Pa.

Introduction

School cardiac service is a complete diagnostic service for cardiacs and cardiac suspects among students and personnel of the school system. It includes referral, examination, diagnosis and recommendation in accordance with the needs of the individual case. The center of its administration is the Heart Station, located in the school Administration Building.

Cardiac service is extended to the entire school enrollment. We are interested in the whole cardiac suspect—his past, present and future. We try to recognize active and inactive stages of rheumatic fever and chorea. Removing the stigma of rheumatic fever, the fear of a "murmur," or the neurosis of an imaginary heart lesion is frequently an important result of cardiac re-examination of heart suspects. We strive for the early recognition of rheumatic heart disease and of congenital cardiovascular anomalies, mainly by clinical methods of examination. Laboratory procedures are used when indicated. Our endeavor is to arrive at an accurate, complete cardiac diagnosis. Suitable recommendations are made, but all treatment is left to the private medical agency, be it family physician, cardiologist, pediatrician or hospital. We urge each parent to secure appropriate medical or surgical treatment for the child if he needs it. The follow-up service to the cardiacs and suspects depends on the requirements of the case.

School personnel who receive cardiac services include applicants for teaching and maintenance positions, periodic re-examinees among food-handlers, and those who return after a prolonged sick leave for heart conditions. Examination of heart suspects is also made in the case of employees whose physical capacity for

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Presented before The American Heart Association, Twenty-fourth Scientific Session, Atlantic City, New Jersey, June 8, 1951.

Medical Supervisor, Cardiologist, School District of Philadelphia; Instructor in Medicine, Jefferson Medical College, Philadelphia.

From Division of Medical Services, Dr. Ruth H. Weaver, Director.

continuation of arduous work is questioned. These may be custodians, helpers or bus drivers, or applicants for extra service as evening school teachers. Many of these consultations are really problems in internal medicine. Of the employees who have received their biennial periodic health examinations, 7.3% were studied electrocardiographically. Consultation requests may come from any administrator or school physician, and reports of these examinations are forwarded to those who requested them. At the request of the examinee, a report is also sent to the private physician. Recommendations are made regarding the particular services of the employee but no treatment is undertaken. The disposition of the case, however, is an implied recommendation. We are mindful of the many factors that enter in the case, not only the nature and severity of the heart disease but its relationship to the patient's work, to his health, and to his domestic situation. For instance, a person with moderate hypertension or moderately advanced organic heart disease may be accepted for grade or academic teaching but rejected for the position of teacher in physical education. Acceptance for a position may or may not carry restriction of physical activities.

Method

The beginning of cardiac service is the preliminary screening of all children by school physicians and nurses. The nurses obtain a brief history, and school physicians make a complete physical examination of one-half of the entire school population biennially. The list of cardiac suspects in a school includes the pupils who are found to have one or more of the following: A history of actual or doubtful rheumatic fever or chorea, actual or questionable organic heart disease, functional disorder, hypertension, tachycardia, functional murmurs, a gymnasium excuse for any heart condition, and any abnormality of the cardiac contour reported on X-ray study. Heart suspects applying for junior employment certificate or seeking to engage in farming during the summer are re-examined. Pupils are also referred for cardiac consultation if their ability to participate in competitive sports is questioned because of a suspected heart condition. Sometimes, the teacher, counselor or other school administrator may nominate a heart suspect for a cardiac consultation. Often the compulsory attendance department (Division of Pupil Personnel and Counseling) refers a child for determination whether his extended absence from school is valid. About one per cent of school children have some form of heart disease,[1]

[1] Cahan, J. M.: The Incidence of Heart Disease in School Children, *Jr. Am. Med. Ass'n.* May 11, 1929, xcii, 1576.

and, on the average, school physicians recommend .6% of all pupils examined for treatment of organic heart disease.

We attempt to avoid overloading our service with unnecessary work, but our experience leads us to believe that re-examination of all heart suspects is necessary if we are not to overlook any organic cardiacs. We have found many cases of rheumatic heart disease and congenital defects among children reported to have so-called "functional murmurs."

After the preliminary screening, a cardiac record form (Form M-94)[2] is initiated by the nurse for every heart suspect. If the child has a private physician or attends a hospital clinic, the cardiac form is given to the child for its completion by the treating agency. If the child is not under the care of any doctor, a cardiac consultation is offered to the parent. If an organic lesion is found, the child is referred to some medical agency for treatment. Whether the child has a physician or not, the cardiac form is sent to our Heart Station.

Almost all heart suspects are then scheduled for a second screening, unless the first examination was made by a cardiologist and the diagnosis was acceptable to us. The re-examinations are made in the Heart Station, in the respective schools, in heart clinics of numerous hospitals and by private cardiologists.

In the Heart Station, a thorough history is obtained from the accompanying parent. As an introduction to the history, I ask the parent: "Has the child ever been ill in bed with fever, at home or in a hospital, for a whole month or more?" The answers differ greatly, are usually quite informative, and permit ample elaboration. After the history is obtained, the child's heart is examined and an electrocardiogram is made. When indicated, an erythrocyte sedimentation rate test and a complete blood count are also made. Whenever advisable, fluoroscopic and X-ray studies are obtained by special arrangement with Dr. Paul C. Swenson of the Jefferson Hospital. In the Heart Station, we also routinely examine the hearts of the accompanying parents and siblings. We are aware of the tendency of rheumatic fever to be present in more than one member of the family, and we therefore examine as many members of the family as possible.[3, 4] The diagnosis is made and a proper

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[2] Cahan, J. M.: The Heart and the School Child, Neo-Aesculapian Press, N. Y., 1949.

[3] Cahan, J. M.: Rheumatic Heart Disease in Families, *Pennsylvania Medical Journal*, Jan., 1941.

[4] Cahan, J. M.: Rheumatic Infection in Families, *Medical Record*, June 18, 1941.

recommendation is included. The school is then notified of the result of the examination by means of a transcript of essential information, including recommendations, which is copied by the nurse on the pupil's general school medical record. If a private physician has referred the child for consultation, a report is sent to him also.

For consultations in the schools, the nurse makes a list of all heart suspects, and arrangements are made for the second cardiac screening. An assistant cardiologist visits the school and re-examines all listed heart suspects. He enters the history, findings and diagnosis on the pupil's general medical record, and on the cardiac record form. He then mails the cardiac forms to the Heart Station, and leaves with the nurse a list of organic cardiacs found in the school. This is the school register of heart cases. The regular school physician is usually eager to attend cardiac consultations, and appreciates this in-service training. In-service training applies also to school nurses who help to get the history, attend the consultations, learn conditions about the cardiac pupils and their homes, follow up the cases, and keep an accurate school cardiac register for later reference. Information about any cardiac transferred to another school is sent to the Heart Station. Care is taken to list for a later examination, or for referral to the Heart Station, any heart suspect who was absent at the time of consultations, as the absentee pupil may be the real cardiac. (Total percentage of all school absenteeism is 9.1%.) When in the opinion of the cardiologist the child requires further study, the heart suspect is referred to the Heart Station.

The Children's Heart Hospital sends a brief report when its patients are discharged if they are eligible to return to school. The information is at once conveyed to the district medical supervisor, for the information of the school. The hospital later sends us a carbon copy of the complete summary of the child's record. Cardiac reports are also received from numerous hospitals and many cardiologists.

Many important points are not covered in this presentation. The details of obtaining a thorough history, the essentials of a good general physical examination and skillful clinical examination of the heart, the recognition of the many variations of heart sounds normally found in children, the detection of valuable diagnostic signs, the proper consideration of laboratory evidence, and details of criteria for complete cardiac diagnosis are not within the scope of this presentation. All of these, however, require thoughtful

evaluation and are important. Details of procedures used in our Heart Station and in the schools are also omitted because of lack of space.

Material

From September, 1945, to May of 1951, cardiac reports of 12,274 heart suspects were critically reviewed. If a physician's diagnosis was "No heart disease," "Potential heart disease" or "Possible heart disease," and there was no entry of a diastolic murmur or other suspicious finding under Examination, we accepted the diagnosis. However, all cases with a diagnosis of organic heart disease were reviewed more critically. Many diagnoses were unacceptable for various reasons. A cardiac consultation was suggested to the physician whenever the reports were incomplete or contained discrepancies between the physical findings and the diagnosis, or when questionable recommendations were made. Strange as it may seem, reports sometimes contained the results of electrocardiographic, fluoroscopic, roentgen, sedimentation and blood count studies, but failed to state whether the heart was enlarged, describe the murmur or check an item under diagnosis. As to recommendations, it was not rare to receive an excuse from gymnasium because of a "functional murmur." For such and other reasons, we offered the attending physician a cardiac consultation, which was accepted in almost all cases. The consultation required and received the approval of the child's parent or guardian. Some parents were unable to pay even the nominal charge of a hospital heart clinic for a consultation. All such cases were referred to our Heart Station where no charge whatever was made, and the needy ones were given free transportation tokens. We found that physicians who do not make careful complete cardiac diagnosis tend to exaggerate rather than underestimate the actual cardiac condition.

The cardiac forms in the Heart Station are arranged by school, public and parochial, and many are filed alphabetically. For each heart suspect there is a master file card arranged alphabetically by name. A list of all congenital cardiovascular anomalies is cross-indexed by the anatomical diagnosis. The number of electrocardiograms taken was 3,035.

Diagnosis

A summary of the cardiac records showed that the diagnoses of 10,864 heart suspects were acceptable, and these form the basis of the tabular calculations in this presentation. The remaining 1,410 cardiac records were unfinished, as their diagnoses were

unacceptable and needed verification.

Congenital defects combined with acquired lesions have been placed in the table of congenital anomalies. The etiology of almost all acquired organic heart disease was rheumatic fever, inactive stage. The diagnosis of cardiac enlargement has been omitted whenever the valvular lesion is specified. By themselves, enlargement of the heart (unless it is marked), a systolic murmur (unless it is due to aortic stenosis), and certain types of arrhythmias may not definitely signify organic heart disease.

In the tables of diagnoses, the original anatomical diagnosis describing the lesion has been retained. No effort was made to express the diagnosis in different words, for a more uniform listing in the table. For instance, "Mitral valvulitis" is so listed in the summary table. For convenience of tabulation, age was disregarded, and the summaries of all heart suspects in the elementary and secondary schools have been combined.

The etiological and anatomical diagnoses are shown in two tables. The remaining three parts of a complete cardiac diagnosis, namely, the physiological diagnosis, the functional classification and the therapeutic classification, were missing in many of our records. These are discussed elsewhere.[5]

Table 1

SCHOOL CARDIAC SUSPECTS

10,864 Acceptable Diagnoses

Diagnosis	Number	Per Cent
Normal hearts	5,918	54.5
Potential heart disease	2,183	20.1
Possible heart disease	1,137	10.5
Organic heart disease	1,626	14.9
Total	10,864	100.0
Organic heart disease:		
Congenital	403	24.8
Acquired	1,223	75.2
Total	1,626	100.0

Table 2

CONGENITAL CARDIOVASCULAR ANOMALIES

Anatomical Diagnosis	Number
Interauricular septal defect	83
Interventricular septal defect	129
Interauricular and interventricular septal defects	2
Interauricular septal defect and rheumatic heart disease	1
Interauricular septal defect, mitral stenosis and dilation of the pulmonary artery (Lutenbacher syndrome)	1

[5] Cahan, J. M.: Rheumatic Heart Disease in Philadelphia School Children, *Annals of Internal Medicine*, Vol. 10, No. 12, June 1937.

Interventricular septal defect and rheumatic heart disease	1
Interventricular septal defect and mitral insufficiency	1
Septal defect and mitral insufficiency	3
Interventricular septal defect and tricuspid damage	1
Interventricular septal defect and transposition of great vessels, operated on	1
Septal defect, undetermined	17
Septal defect and supracardiac mass	1
Patent ductus arteriosus, twenty-five operated on	57
Patent ductus arteriosus and septal defect	1
Coarctation of aorta, three operated on	5
Tetralogy of Fallot, seven operated on	14
Subaortic stenosis	25
Subaortic stenosis and interventricular septal defect	1
Subaortic stenosis and interauricular or interventricular septal defect	1
Right-sided aortic arch	1
Pulmonary stenosis	6
Congenital anomalies, lesions undetermined	51
Total	403
Dextrocardia, true (accrued since 1920)[6].	

Table 3

ACQUIRED ORGANIC HEART DISEASE

Anatomical Diagnosis	Number
Rheumatic fever, active	3
Rheumatic heart disease, inactive	40
Cardiac enlargement	27
Mitral insufficiency	657
Mitral stenosis, questionable	9
Mitral stenosis	77
Mitral insufficiency and questionable mitral stenosis	1
Mitral insufficiency and stenosis (one, fibrillating)	131
Mitral valvulitis, rheumatic	80
Mitral and aortic valvulitis	2
Aortic insufficiency	55
Aortic stenosis	7
Aortic insufficiency and mitral insufficiency	65
Aortic insufficiency and mitral stenosis	8
Aortic insufficiency and double mitral	14
Aortic insufficiency and stenosis	4
Aortic stenosis and mitral insufficiency	8
Double aortic and mitral insufficiency	5
Double aortic and double mitral	9
Aortic insufficiency and pulmonary insufficiency	1
Aortic valvulitis	3
Pulmonary embolism and auricular fibrillation, convalescing	1
Subacute bacterial endocarditis, active	1
Subacute bacterial endocarditis, inactive	2
Pericarditis	5
Pericarditis and mitral insufficiency	1
Pericarditis, tuberculous	1
Postural hypotension	1
Coronary sclerosis and hypertension	1
Heart disease, lesions undetermined	4
Total	1,223

[6] Cahan, J. M.: Transposition of all the Viscera, *Medical Journal and Record*, July 15, 1925.

Limitations and Fallacies of Summarized Cardiac Records

Unfortunately, there were many items on the cardiac form that were not summarized because entries were missing. The cardiac form is very comprehensive and contains 78 items arranged for convenient checking, and much information could have been derived from an analysis of completely filled out forms. The history was checked, as a whole, whether there was no history, a negative history, a suspicious or an actual history. Summaries of these records have been accumulative, not annual.

Only sample summaries of certain items at random can be reported. For instance, of 5,623 known histories, 3,188 (57%) were negative, 1,305 (23%) were suspicious, and 1,130 (20%) were actual.

Of a total of 3,385 recorded medical attendants, 2,575 (76%) were private physicians, 714 (21%) were cardiac clinics, 84 (2.5%) were hospitals, and 12 (.3%) were convalescent homes.

Of 879 functional diagnoses checked 478 (54%) were Class I, 345 (39%) Class II, 54 (6.1%) Class III, and 2 (.2%) Class IV.

Of 860 recorded therapeutic classifications 229 (27%) were Class A, 447 (52%) Class B, 155 (18%) Class C, 23 (2.7%) Class D, and 6 (.7%) Class E.

As to recommendations, of the 9,708 cases tabulated, 427 (4.4%) had some form of gymnasium excuse, 43 (.4%) had elevator permits, 146 (1.5%) had visiting home teachers, and 9,092 (93.7%) were attending regular class without special privileges.

Recommendation

Recommendation is an essential part of the therapeutic diagnosis. Even when there is no heart disease or when the diagnosis is the so-called "potential" or "possible heart disease", for the information of the school administrators and teachers, it is important to state definitely if the child is to be given any special privilege. If there is any restriction of physical activity, the degree of restriction must be specified.

One or more of the following special privileges may be prescribed for a pupil, depending on his needs:

1. Attendance at a more convenient school because of a heart condition which requires:
   (a) better transportation
   (b) less traveling distance
   (c) elevator facility
   (d) a classroom on a lower floor

2. Free carfare tokens or free "bus" fare
3. Special pass to permit the use of special school entrance or exit
4. Permission to enter or leave school before or after the regular time scheduled for other children, to avoid a congested hallway
5. Permission to trail at the end of the line, walk without regard to movement of classmates, or rest on the stairs if necessary
6. The use of elevator, if there is one in the building
7. Permission to use a toilet on the floor nearest to the classroom
8. Excuse for any lateness or absence
9. Avoidance of acting as messenger
10. Avoidance of Safety Patrol duty
11. Avoidance of disciplinary measures if pupil is nervous
12. If possible, permission to remain in the classroom during recess and lunch, or lengthening of the lunch hour to avoid haste
13. Permission to retire from the classroom for a rest period when necessary
14. Avoidance of standing during class recitation
15. Avoidance of homework
16. Permission to attend only one school session
17. Excuse from calisthenics and physicial education as per executed form for restriction of physical activities.[5]
18. Special provision for safety during a fire drill or atom bomb (retention) drill
19. Assignment of a visiting home teacher
20. Any other privilege or health guidance, such as advice on educational progress in school or subsequently in college. Vocation needs and avocational wishes are to be kept in mind.

With reference to the official school form for restriction of physical activities, physicians often request gymnasium excuses that are unwarranted by the stated diagnosis, but by a rule of the Board of Education the school is required to honor such a request for a period of not over three months. If we disagree with the private physician, we write him after the cardiac consultation, and advise him of our recommendation. In the majority of cases the physician agress with our change in the recommendation, rescinding all or part of the restrictions. We feel that physical education is beneficial to the child's physical and mental health and to his future. As a general rule, it is safe to allow the pupil who has an organic heart condition to exercise at will, but participation in competitive sports, if allowed at all, requires frequent periodic medical re-examiation.

This precaution is necessary if the fatigued cardiac is not to sustain "accidents" more frequently than the normal child. Explanation of degrees of restrictions of physical activities appear elsewhere.[5]

Recommendation for management of congenital, cardiovascular anomalies such as patent ductus arteriosus, coarctation of aorta, tetralogy of Fallot, and other operable defects includes further studies and consideration of ameliorating or correcting the defect by operation, at an optimum age. We make a special effort to interest the family physician and parents in essential studies preliminary to surgical treatment. The interest in such cases should extend to the pre-school children, those under five years of age. If a child has a cardiac anomaly that can be improved or cured by surgery, the parent and the family physician should consider that question as a part of the preparation of the child for school.

(To be continued)

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[5]Cahan, J. M.: Rheumatic Heart Disease in Philadelphia School Children, Annals of Internal Medicine, Vol. 10, No. 12, June 1937.

PRESIDENT'S REPORT AND RECOMMENDATIONS—1951-1952

This year perhaps more than any other preceding year there would seem to be a feeling, among the nurses at least, that the American School Health Association is blending together all aspects of school health into an integrated Association of professional workers. As your first nurse-president, may I express to the Association the keen appreciation of the school nurses for the recognition you have given them and their work by having a nurse-president. May I also say that it has been an interesting and thrilling experience as well as a most satisfactory one because of the support and kindly help which the other members of the Association have so willingly given. The committee work seems to have gone along in many areas, as in former years, and your president wishes to express to each committee chairman her appreciation for the work they have done this year.

It is not until one becomes president of such an Association that they fully appreciate those at the helm who make the wheels turn. Without Dr. A. O. DeWeese and Dr. Charles Keene the task of being president would be most difficult if not well-nigh impossible. These two people are carrying a load most of us little realize. The finances of the Association are being depleted a bit more rapidly than the income warrants. This is not a healthy situation and one which can best be remedied if each and every member would secure one or two new members during the coming year. The value of our Journal is well recognized by the membership and should be the Association's best selling point (10 issues for $3.00). With a larger membership reading the Journal, advertising space would be more easily sold, thus further reducing the cost of the Journal to the membership. Thus my first recommendation: That each member do his part in securing new members for the Association rather than at this time raising dues for the present members. (A list of state membership chairmen will be published in an early issue of the Journal.)

My next recommendations concern the need to enlarge and strengthen our relations with other organizations having similar interests and joint responsibilities. A few years ago the Governing Council discussed the feasibility of meeting with the American Association of School Administrators in order to bring about a closer working relationship. The 1951-1952 President of the American Association of School Administrators is Dr. Kenneth Oberholtzer, Superintendent of Schools in Denver, so your president took it upon herself to talk with Dr. Oberholtzer about some such plan. As expected, his reaction was that when the School Admin-

istrators meet as a total group, it is already a formidable undertaking, and the school health people would be the 31st affiliating group meeting at the same time and place. Atlantic City seems to be the only city able to entertain so large a group and the meetings are now so unwieldy they are not satisfactory. However, Dr. Oberholtzer did have one or two worthwhile suggestions to make to the American School Health Association and I pass them on to you for further consideration. The American Association of School Administrators occasionally meets in regional groups as they are doing in 1952 and probably will again in 1955. He suggests that sections of the American School Health Association seek an opportunity to meet with the regional groups and suggests that the School Health Association plan at least one session for themselves which would be of interest to both school health people and school administrators. He then suggests that the health people should join in the other sectional meetings and contribute wherever there were chances to make their special contributions. Another proposal made by Dr. Oberholtzer was that whenever the School Health Association has committees to set up standards, plan programs and promote public relations which might involve a cost to the school systems or administrative action on the part of the general administrative group, that they include some interested school administrators on such committees. This last proposal is one about which he feels very strongly. If we do include school administrators on committees, this would encourage better inter-professional teamwork. I should like, then, to make as my second recommendation the plan to meet with the school administrators in 1955 in at least one or more regional areas.

The third recommendation is that we have a committee to study and define more specifically the functions and responsibilities of the school health program as differentiated from the general over-all community health program. On this committee should be, if possible, one or two school administrators.

A fourth recommendation is predicated on the fact that 1952 is the twenty-fifth anniversary of this Association and your president suggests that special attention be given to some form of celebrating this event.

In conclusion may I again thank each and every one of you, Dr. Keene, Dr. DeWeese, Dr. Magness and each committee chairman who has so faithfully served one of the best Associations in the field of school health. Let each of us determine to secure a stronger and larger membership for 1951-1952 and on through the next twenty-five years.—*Gertrude E. Cromwell.*

NATIONAL CONFERENCE ON MOBILIZATION OF HEALTH EDUCATION, PHYSICAL EDUCATION AND RECREATION

A. LOUISE MCNIFF*
Supervising Teacher in Charge of Health Education, Denver Public Schools

The National Conference on Mobilization of Health Education, Physical Education and Recreation was held in Washington, D. C., March 19 to 21 of this year. There were approximately 85 organizations represented with over 200 persons in attendance.

The work of the various committees that planned the conference is to be commended. This ground work was evident in the smooth way in which the meetings progressed. Those who participated felt that much was accomplished in the short time set aside for this important conference. Each area, Health, Physical Education and Recreation, had its own leader and all were coordinated under the able leadership of Dr. Frank S. Stafford of the Office of Education, Washington, D. C.

The purposes of the conference were:

1. To study the needs created by the national and international situation.
2. To develop suggestions for state and local planning.
3. To make specific recommendations for the mobilization of resources.
4. To discuss existing programs of health education, physical education and recreation in order to identify undeveloped or neglected areas.

It is hoped that the conference will result in a better understanding of the contributions that health education, physical education and recreation can make to meeting the health and fitness needs of children, youth and adults.

The present critical world situation has brought about a national emergency of undetermined length. The nature of the crisis imposes upon us great demands, under conditions of varying difficulty and uncertainty, when we must function at the highest possible level of our abilities. A long-term period of mobilization will be a disruptive influence on the stability of home and community life. These conditions create new needs and intensify old ones which cannot be ignored by school and community leaders.

The group considering the changes which might affect children, kindergarten through grade six, approached the problem by

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identifying ten needs of children today. These are listed as:

1. Feeling of security
2. Self confidence
3. Understandings, attitudes, and skills that are undeveloped by a well-rounded program of health instruction.
4. Optimum health and fitness
5. Active participation in planning for own health and protection
6. Favorable environment that frees child from fear and war anxieties.
7. Protective services such as immunizations
8. Knowledge of own potentialities and limitations
9. Respect for others
10. Sense of responsibility.

While these needs are not new, viewing them in the light of an emergency gives them different implications.

The home, school, and community must accept cooperatively the joint responsibility for meeting these health needs of children, with each playing its unique role, as determined by mutual agreement on plans and policies. Available school and community resources should be utilized and untapped sources of leadership discovered. Preparation of personnel by means of in-service training, and education of parents and community non-professional groups is necessary. This entails the full administrative support of school and community, delegating responsible leadership and cooperative group planning. The curriculum must be reviewed in terms of local needs and all possible teaching aids should be provided. Appraisal, guidance and follow-up is essential on the part of the school and home. A healthful environment should be provided which will assure optimum pupil growth and development.

The group studying the problems of "Youth of Junior and Senior High School Age" believe that the health instruction program should be carefully planned and accelerated to meet the needs of the school and community in the emergency situation as well as for a long term program, in order to have a healthy people. This planned over-all program should have the objective of developing desirable practices and attitudes, and an acceptance of responsibility for personal and community health.

Health instruction based on the needs and interests of children should have equal rights with other courses in the curriculum as to facilities, equipment, enrollment and credit. There should be a time allotment of at least a daily period for one semester on both the junior and senior high school levels, in addition to the time for

physical education. Many other classes in the school should supplement the health instruction program. While it becomes necessary in times of emergency to stress such areas as first aid, home nursing and mental health, it is important that they be included as an integral and coordinated part of the total health instruction program in normal situations as well.

It is believed that problem solving techniques that will give students skills in solving their own health problems should be employed in teaching these classes. Apron strings must be cut so that children could look after their own needs if they were separated from their families.

Medical and dental examinations of all children on or before entrance to school, followed by one in the intermediate grades, one during early adolescence, and one before leaving school, should be given if possible. First priority should be given to the entrance examination and second priority to the one in early adolescence if four are impossible. Parents should be encouraged to have these examinations given by the family physician if possible. Prompt examinations should be arranged for children referred by teachers or nurses when something appears to be wrong with the child. A program of continuous observation by teachers and nurses skilled in detecting these changes helps to identify children who need referral. Periodic screening procedures, such as weight and height measurements, and vision and hearing tests are desirable.

A coordinated follow-up program to encourage parents to provide needed protective and corrective measures is necessary and cumulative health records should be kept. There should be an understanding among pupils, teachers and parents of the procedures to be followed in emergencies, including ways of handling accidents, sudden illness and disaster situations. The schools should cooperate with the health department in all policies and practices of communicable disease control with emphasis upon booster doses as recommended by local departments of health.

It is imperative that complete cooperation be extended to the Civilian Defense efforts devised for the emergency, such as the use of the school plant for an emergency shelter and feeding station. Since the pressures upon secondary school pupils to participate in defense and security activities may increase, teachers should be alert to help pupils to accept such responsibilities wisely and to maintain balance in daily living.

The health of the teacher and other school personnel vitally affects the health of children. Teaching and working conditions

must be sanitary and safe; teaching and working loads must be reasonable. Health examinations and chest X-rays previous to employment and periodically thereafter should be required.

Colleges are urged to strengthen their program for all teachers to include an understanding of the over-all school health program and health services. Teachers should be prepared to accept a wider role in health service in the light of possible shortage of physicians and nurses during the emergency. They should be prepared also to handle wisely situations involving the emotional impact of the emergency upon children.

The group working on "Adult Health Education," has considered the proper answer to the problem of health in the present and continuing emergency to be that of making effective use of what we have.

In defining the present problem of adult education we are concerned with the college and the extra-college adult community. Recommendations for the college phase of adult education are based broadly upon a report of the third national conference on health in colleges, "A Health Program for Colleges." The committee feels that the college problems which require present emphasis are:

College Administration and the Health Program

1. Better use of available personnel because of expected shortages.
2. Recognition and acceptance of the defense responsibility of the college to the community.
3. Development and maintenance of the highest health potential for all personnel.
4. Preparation of students psychologically, physically and vocationally to meet their changing roles in military service or employment in connection with the war effort.
5. Establishment of a coordinated plan to keep students informed to the end that they will neither be unduly affected by rumors or ungrounded fears nor will they take hasty and unwarranted action.

Health Service

1. The most effective use of all available professional personnel in health appraisal and health maintenance.
2. Recognition and assumption of its new responsibilities in the defense program, such as the blood program, health counseling for the emergency, and provision for emergency medical care.
3. Development and maintenance of the highest health potential among students.

Health Instruction

1. Teaching health dangers and civilian defense procedures.
2. Teaching principles of mental health and their application to current situations.
3. Preparation for family living under the emergency situation:
   (a) housing
   (b) economics
   (c) nutrition
   (d) mobility of families
   (e) marriages (problems of hasty or delayed marriages)
4. Teaching the nature and utilization of community health resources.
5. Increased emphasis on health eduction for all college students in reference to the emergency responsibilities of individual vocations.
6. Consideration of world health problems.
7. In-service education in health for teachers.

Healthful living

Adjustment of environmental, psychological, and social welfare factors to fit the emergency.

In the community, problems of adult health education have another phase apart from college education and that is health education of the general adult population.

The first aspect of this phase is community planning for the promotion of health and the strengthening of community health resources. Many frameworks for action in community planning for health exist. One of the best is Public Health Bulletin No. 304*—Planning for Health Services—A Guide for State and Communities.

Community planning may be initiated by colleges, schools, health departments and other community agencies. In any case, school participation is important.

The second aspect of adult health education for the general population is civil defense for disaster. Plans for this program are developing in states under official civil defense organizations.

The complete report of the conference on mobilization of education will be available from the Federal Security Agency, Washington, D. C.

*United States Public Health Service.

CRIPPLED CHILDREN'S SERVICES

BY ANNA E. LALLY
Orthopedic Nurse Consultant

New Hampshire State Department of Health through its Bureau of Crippled Children's Services, renders assistance to individuals under 21 who have conditions which are crippling or likely to lead to crippling. The program includes the following:—

1. Locating crippled children and maintaining a State Register of those needing care.
2. Providing diagnostic services by qualified physicians through state clinics located in permanent centers or held periodically in other areas, so that they may be accessible to all parts of the state.
3. Providing treatment by qualified physicians at the state clinics, hospitals or convalescent homes properly equipped to care for such cases.
4. Providing nursing follow-up, physical therapy, medical social service for children receiving care.
5. Cooperating with other public and private agencies in planning for follow-up care and rehabilitation of children receiving services.
6. Occasionally paying for foster home care, when boarding away from home may be necessary because of special treatments.
7. Conducting, in conjunction with the Bureau of Vital Statistics, a program for follow-up of children reported by birth record to have birth injury, congenital deformity or disease.

The program is essentially for rehabilitation. The child's status must be such that treatment will benefit the condition or facilitate care and management of the child, with a view to decreasing dependency. New Hampshire has no legal definition of a crippled child; however, for administrative purposes, many congenital and acquired conditions which are crippling or likely to lead to crippling are listed as eligible for assistance. Congenital deformities include defects such as the following:—Club foot, torticollis, spina bifida, cleft palate and harelip, cerebral palsy, webbing of fingers and toes. Acquired deformities, due to disease or trauma (frequently a combination of both) include such disabilities as from poliomyelitis, paralysis occurring at birth, arthritis, accidents, and contractures due to burns. Crippled Children's Services does not provide care immediately following an injury.

No means test is required to determine whether persons are eligible for financial assistance, but knowledge is acquired as to whether aid is needed; in some instances the family may make partial payment for appliances, hospital care, and other diagnostic and treatment services. New Hampshire Health News, Nov. 1951, p. 96.

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EDITORIALS

The Convention

The 1951 Convention of the American School Health Association was a very successful one, professionally and socially.

The attendance at the meetings was about one-half that at the St. Louis Convention in 1950. However, St. Louis is close to the center of the population of the United States. Considering geography and the cost of travel—the Federal tax on an airplane round-trip ticket between Buffalo and San Francisco is $40—, the San Francisco attendance was excellent.

While several friends of long standing were absent, the Governing Council meetings were extremely well attended.

The major topics of consideration by the Council were finance, i.e., membership, advertising in the Journal, costs of publication, the Budget for 1951-1952, and the Reports of Committees.

The Association year 1950-1951, under the administration of President Gertrude E. Cromwell, has been a very successful one. Definite progress is being made in rounding out a more definite concept of what the modern school health program is, and in emphasizing the idea and feeling that true progress in school health rests in a united group of the workers in that field. A divided allegiance is ruinous to real advancement.—*C.H.K.*

Athletics — Play or Business

The editorial office window looks out over the playfields of the University. There—weather permitting—is shown an almost continuous program of games and physical activities which we may justly classify as sport-play.

For many years all physical activities in colleges, and later, in secondary schools, took this form—play—by, for, and under the management of students.

While this writer does not advocate a complete return to this simplified program—the group and type of athletics has become too complicated, and the student body too large—the type of thing we see from our window has many things to recommend it.

The players *play* and because they want to; the officials are students—unpaid—and because they like to officiate; spectators, few in number, but always some, are there because they want to be, not because they must attend—to support the "old school"—and they are nonpaying guests; applause is also voluntary and not what I once heard a celebrated English surgeon call "manufactured cheering."

This picture is so far different from the present intercollegiate and secondary school picture of athletics, the murky scandals of which have been displayed before you in the daily press—and the responsibility for this condition we may fairly charge somewhat to the sports pages of the press—that we should seriously consider the possibility and desirability of getting back, somewhat at least, to the early status of voluntary athletics.

Already some schools are changing their procedures. Some have dropped football (which seems to be the game most criticized, although it is not the one in which has been exhibited the most dishonesty); some are dropping or shortening spring practice; some are being forced, by the cost, to conduct intercollegiate competition on a less expensive and more honest basis.

Perhaps the games may get back more into the hands of the students and become play again.

Anyhow, the present conditions have placed on the administrative heads of these institutions serious ethical and financial problems. What will they do about them?—*C.H.K.*

ABSTRACTS and NOTES

School Health: A Needed Reform,*—Section 53 of chapter 71, General Laws, Massachusetts, provides that physicians and nurses shall be provided and assigned to the public schools in each community. Towns having a valuation of less than one million dollars may be exempted from so much of this section as relates to nurses.

Under a modern school health program, what is desired of the school physician has become a fairly exacting requirement. As it becomes more exacting, so must the inducements be increased in order that what is to be done will be well done. It is not the main purpose of this article to speak for higher pay for school physicians but to point to prevalent weakness of local school health administration which weighs heavily against progress. We cannot, however, leave the subject of pay without indicating our concern. A dignified rate of pay is essential if it is desired that a community's school health services reach a dignified standard. Not only should the rate of pay be worthy of the effort, but to attract a physician's serious consideration the salary for his school assignment should be a considerable portion of his income.

It would be nice were school salaries higher but there are other considerations than salary boosts which are of importance to a school physician. Among these considerations are the size of his assignment. A part-time school physician can well be responsible for an assignment or "borough" of from 2,000 to 2,500. It is probable that the most economical use of school health funds from the point of view of returns may come from a unit of about that size. Such an assignment would not only call for a substantial salary, but would also be large enough to claim the physician's more serious consideration. Many of the over 600 school physicians in Massachusetts have a much smaller school responsibility. Of 361 Massachusetts communities only about 65 have over 2,000 school children. Some hamlets have only a few dozen school children. These villages are usually members of superintendency unions. Why should they not also share the services of a school physician?

It is not only in these small communities that reform is needed in school health administration, but in a number of larger ones where established practice has led to the division of the school health responsibility into small insignificant fractions — where school physicians are appointed for each school building—where the school physician's responsibility appears to be deliberately made as diminutive as possible. In the words of "Uncle Dudley" in the Boston Globe, "It is not a way of obtaining good services."

*_News Letter_, Massachusetts Department of Public Health.

An incoming school physician will find that a thorough understanding of the possibilities of school medical practice will pay real dividends in the sense of satisfaction which his work will bring to him—a greater sense of real achievement. It is not yet generally realized that a modern school health program has come to demand of the physician a special orientation.

The field of school medical practice as yet is accorded no attention in the medical school curriculum. Consequently the school physician must receive this orientation after graduation. The trouble with school medical practice in the past (and it was well advertised that there was trouble) was not surprising in the absence of any attempt at orientation to the special possibilities of school work. The average school physician in those days was searching for physical illness or physical handicap. He thought little of the opportunity for prevention of illness except as related to the control of contagion. He thought not at all of his opportunity for health education.

There is a very close relation between the reform of the school physician's "boroughs," as we might call them, and success in cultivating better school health services. The proper orientation of a school physician is a time-taking process not entirely devoid of expense. Is the school physician with less than a few hundred school children to spend time and money acquiring orientation? Not, we believe, unless he is exceptionally well paid.

The Department of Public Health, long conscious of the need for special orientation, has initiated in the past four years several short lecture courses with the collaboration of the Harvard School of Public Health. Much more substantial courses are felt to be necessary. Unless the physician has a substantial school responsibility, it is doubtful if he will accept such substantial periods of training.

In New York City no school physician receives a school appointment without a thorough preliminary orientation. To show the difficulties of giving orientation to the small-town school physician or the physician whose school responsibilities are reduced to a minimum, it will be interesting to know the rough outlines of the New York City preliminary training. This is a six-weeks course requiring the time of the candidates three hours per day five mornings per week. During the training period, however, candidates are on regular school physician pay (which in New York is modest even by New England standards).

We believe that a course of three weeks would accomplish

nearly as much. The Department is trying to arrange such a course in Massachusetts, shorter than New York's, but yet a far more substantial and comprehensive training facility than has been available in the past. We wonder if school committees and administrators cannot gradually combine small school groups, reducing the number of school physicians and giving them larger assignments so that the size of their responsibility (and perhaps their pay as well) will make them eligible for such orientation.

Massachusetts has about 650,000 children in its public schools. Our lists contain the names of 618 school physicians. Were each to be allotted about 2,000 school children, only 325 would be necessary. While we fully realize that geographic reasons will prevent a reduction to such an optimum figure, it should be possible at least to approach it.

Such reform is urgently needed. It is necessary in order that all school physicians may appreciate their opportunity, give it serious consideration, and take satisfaction in their work. It is necessary in order that all school children, not merely those in the larger population centers, may receive the best school health supervision obtainable. Allan R. Cunningham, M.D., Chief, School Health Section, Massachusetts Department of Public Health.

* * * * *

The Dangerous Age,—Much has been spoken and written,—and that heatedly,—on the benefits and on the dangers of this "manly sport," football. If this game were in fact played by men, in the true anatomic and developmental sense of the word, many of the arguments about its dangers would be obviated. Physicians, however, even leaving aside for the moment the possible effects of "overemphasis" on the psyche of the adolescent, should be more articulate about the actual increased physical dangers that are inherent in the playing of this game by boys who are still in the growing age—and growing should not be regarded as confined to height alone.

Elsewhere in this issue of the *Journal* is an article by Leavitt on traumatic separation of the lower epiphysis of the femur sustained by football players of the precollege age. Admittedly, this injury is rare, but it may result in serious and lasting disability.

Injury to athletes of college age, whether they be in the last year of high school or actually in college, are now receiving more effective treatment than ever before, and with this better care, improved preventative measures are being used—such as the protective strapping of knee joints and ankles.

The sad part of the story is that the age when bone and joint injury may be more serious, not only in the immediate nature of the injury but also as regards later functional results,—this dangerous age of fourteen or eighteen years,—is also the age at which the player is least likely to receive the necessary supervision, both for adequate treatment of injuries and for proper prevention and protection against them. Many a youth has been incapacitated for college football by such injuries, especially of the knee, sustained and inadequately treated during his precollege years. Abstract from Editorial, N. E. Journ. Med., Oct. 11, 1951, p. 584.

* * * * *

Traumatic Separation of the Lower-Femoral Epiphysis,*—In recent years traumatic separation of the epiphysis of the lower femur has been observed to occur among schoolboy football players. The injured player, as a rule, is unable to give an accurate account of how the accident occurred; however, it seems likely that the injury results from a direct blow to the body together with a twisting in the region of the upper thigh or knee at a moment when the foot is more or less firmly fixed.

Two cases of separation of the lower-femural epiphysis are reported. Both occurred in football at ages 15 and 16. We believe that prompt reduction contributed to the good results in these cases. Full anesthesia for complete relaxation and with careful nontraumatic reduction are essentials. Rough handling during moving and during reduction must be avoided. Immediate reduction is highly desirable. This can be carried out even on the football field, and with a minimum of pain, if the attending physician thoroughly understands the nature of the injury. Early reduction of the lower end of the metaphysis is essential to the prevention of catastrophic injury to the vessels and nerves in the popliteal space.

We believe that once a good reduction is obtained, the possibility of slipping is very small. Splinting, rather than traction, and early ambulation are indicated. X-ray follow-up will determine the need of a cast or splint, and physiotherapy should be started as soon as possible. Abstract from *N. E. Journ. Med.*, Oct. 11, 1951, p. 565.

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Conference on Physicians and Schools,—An important two-day Conference of Physicians and Schools was held in Urbana in November. The first of its kind in this state, the meeting was sponsored by the Illinois State Medical Society, the Illinois Dental

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*From the Surgical Service, Goddard Hospital, Brocton, Mass.

Pierce H. Leavitt, M.D., Surgeon, Goddard Hospital, Brocton; consulting surgeon, St. Luke's Hospital, Middleboro, Massachusetts.

Society, the Illinois Department of Public Health and the Illinois Department of Public Instruction.

Representatives of all agencies, as well as individuals, interested in the schools and health of school children of Illinois, were invited to attend the sessions which opened at 9:00 A.M. on Thursday, November 15, in the Illini Building on the campus of the University of Illinois.

The general theme of the conference was School Health Services. Specific topics discussed included control of communicable diseases, accident prevention, emergency care, health aspects of physical education, and other subjects suggested throughout the meeting.

* * * * *

Hanover Turns On Heat,—Eating establishments in Hanover County, Virginia, have been getting into trouble over hot water, Sanitarian Vaughan of the County Health Department stated recently, because of failure to provide adequate supplies of that commodity. During the past two years, he said, eleven eating places in the county had been shut down permanently for lack of proper buildings or equipment. Most of these closings were due to inadequate hot water supplies for washing and sanitizing their eating and drinking utensils. Health Officers News Digest, Sept., 1951, p. 5.

* * * * *

Physicians for Rural Areas—*A Factor in Their Procurement. Harold S. Diehl, M.D., Minneapolis.* A recent study indicates that 58 per cent of the medical school graduates who grew up in communities of less than 5,000 population returned to practice medicine in communities of similar size, while only 22 per cent of the students who grew up in large cities established practice in rural areas. In other words, the chances are more than two and a half times as great that a medical student who has grown up in a rural community will practice medicine in a rural area as that a medical student who has spent his life in a large city will establish practice in a country location. The table shows also that 44 per cent of the students who grew up in communities of 5,000 to 100,000 returned to practice in communities of similar size and that 64 per cent of the students who grew up in the large cities established practice in these same cities.

Conclusion: One effective way to increase the number of physicians in rural communities is to increase the number of medical students from rural areas. This might be done by preferential consideration to applicants for medical school from rural communities, or, better still, by encouragement and assistance to well qualified young men and women from rural areas to attend medical school. Abstract from Journal A.M.A., April 14, 1951, p. 1134.

Public School for Palsied Children,—A public school for 49 cerebral palsied children, who have never attended public school, was opened in Clifton, New Jersey, this fall in the Passaic County Elks Cerebral Palsy Center. The children will receive both schooling and therapeutic training there. Specially constructed chairs and tables are provided. Subjects are those taught in the city's regular public schools. Funds for the school are furnished by Clifton and the state, with Passaic County communities paying a share for each cerebral palsied child sent to the school. The three teachers have no more than ten pupils in the class at one time as instruction is largely on an individual basis. Journal A.M.A., Nov. 24, 1951, p. 1288.

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ANNOUNCEMENTS

Of interest to school nurses is the announcement of the appointment of **Mrs. Joan Bochat** as public relations director of the American Nurses Association. She is replacing Miss Jean Thurston who has resigned and the Association is to be congratulated in securing so well-prepared a person to work with them during this important period of the structure revision.

Mrs. Ruth J. Frantz who for the past five years has been Director of Health Education, Wisconsin Anti-Tuberculosis Association, Milwaukee, Wisconsin, is now College Health Co-ordinator, Northern Illinois State Teachers College, DeKalb, Illinois.

* * * * *

Sally Lucas Jean,—The Cleveland Health Museum selected Sally Lucas Jean, former director, Health Education Division, American Child Health Association, and retired director, Education Service, National Foundation for Infantile Paralysis, as recipient of the museum's eighth Elisabeth S. Prentiss National Award in Health Education. The placque and citation, given annually, was presented October 30 at the 11th annual breakfast meeting of the museum's national advisory council, held in San Francisco.

REVIEWS

Nutrition for Health. *Holger Frederick Kilander.* McGraw-Hill Book Company, Inc., New York, 415 pp. Price $3.00.

There is magic in food, declares Dr. Kilander in his suggestive and stimulating presentation of basic scientific principles of nutrition, indicating the effects of different foods upon the body and the choice of foods so wide that it is imperative for the teacher, as well as the individual, to know something about foods and his own special needs for the various substances they contain. His diet must supply him, firstly, with the essential elements necessary for maintaining his body in perfect working order; and, secondly, it must supply him with enough fuel food to meet the greater demands upon the body.

Every diet consists of the same essential ingredients: Proteins, carbohydrates, fats, vitamins, minerals and water. To enable one to calculate his own normal dietary requirements easily and quickly Table 10 is an interesting analysis of the nutritive value of over 200 foods listed alphabetically. The amount of food for which values are given is expressed in clear, understandable household measures.

The Nutritional Yardstick (Recommended Daily Dietary Allowances) described in Chapter 2 will be a very fruitful experience for any teacher desiring to work out a unit or project for classroom purposes. Questions for class discussion and for personal application are given at the end of each chapter.

The bibliography lists some of the most current references available, and the list of visual aids and their source will be of particular interest to all classroom teachers and health workers.

The scope of the text is best indicated by the chapter content:

1. Overview of the facts known about nutrition;
2. Recommended Daily Dietary Allowance;
3. Studies of American dietaries showing common food deficiencies:

4-9. The major groups of nutrients—carbohydrates, fats, proteins, minerals and vitamins;

10. The basic seven food groups;
11. The necessity for planning meals;

12 and 13. The elementary facts of digestion;

14 to 17. Four special phases regarding food and nutrition—

a. Reducing and gaining weight,
b. Food conservation,
c. Food sanitation,
d. Food laws.

Amply illustrated with simple and informative cuts, special appendix tables, sample menus and other material, this is an extremely valuable text for the use of teachers, nutritionists and others who desire teachable material in this field.—*F. W. Febel.*

* * * * *

Developing Democratic Human Relations Through Health Education, Physical Education, and Recreation. *American Association for Health, Physical Education, and Recreation.* A Department of the National Education Association, 1201 Sixteenth Street, N.W., Washington 6, D.C., 562 pp., Price $4.25, NEA quantity discounts.

This first yearbook of the American Association for Health, Physical Education, and Recreation has resulted from two years of planning, writing and editing by 40 men and women who are national leaders in the areas of health education, physical education and recreation.

The yearbook considers the problem of developing democratic human relations as it pertains to the progressive acquiring of democratic concepts and attitudes thru childhood, early and late adolescence, and adulthood. Methods are described for helping individuals to develop as democratic persons at different stages of development. Ways to evaluate whether or not the concepts and attitudes are actually being acquired are explained. The authors have drawn upon recent research in the fields of group dynamics, sociometry, social group work and general education for methods and techniques that may be applied in health education, physical education and recreation.

The basic point of view is presented in chapters entitled *People in Today's World; Democratic Behavior; the Related Fields;* and, *Democratic Leadership.* Programs for children, adolescents, older youth and adults are considered in terms of environment; concepts and attitudes to be developed; methods; and, evaluation.

H. F. KILANDER

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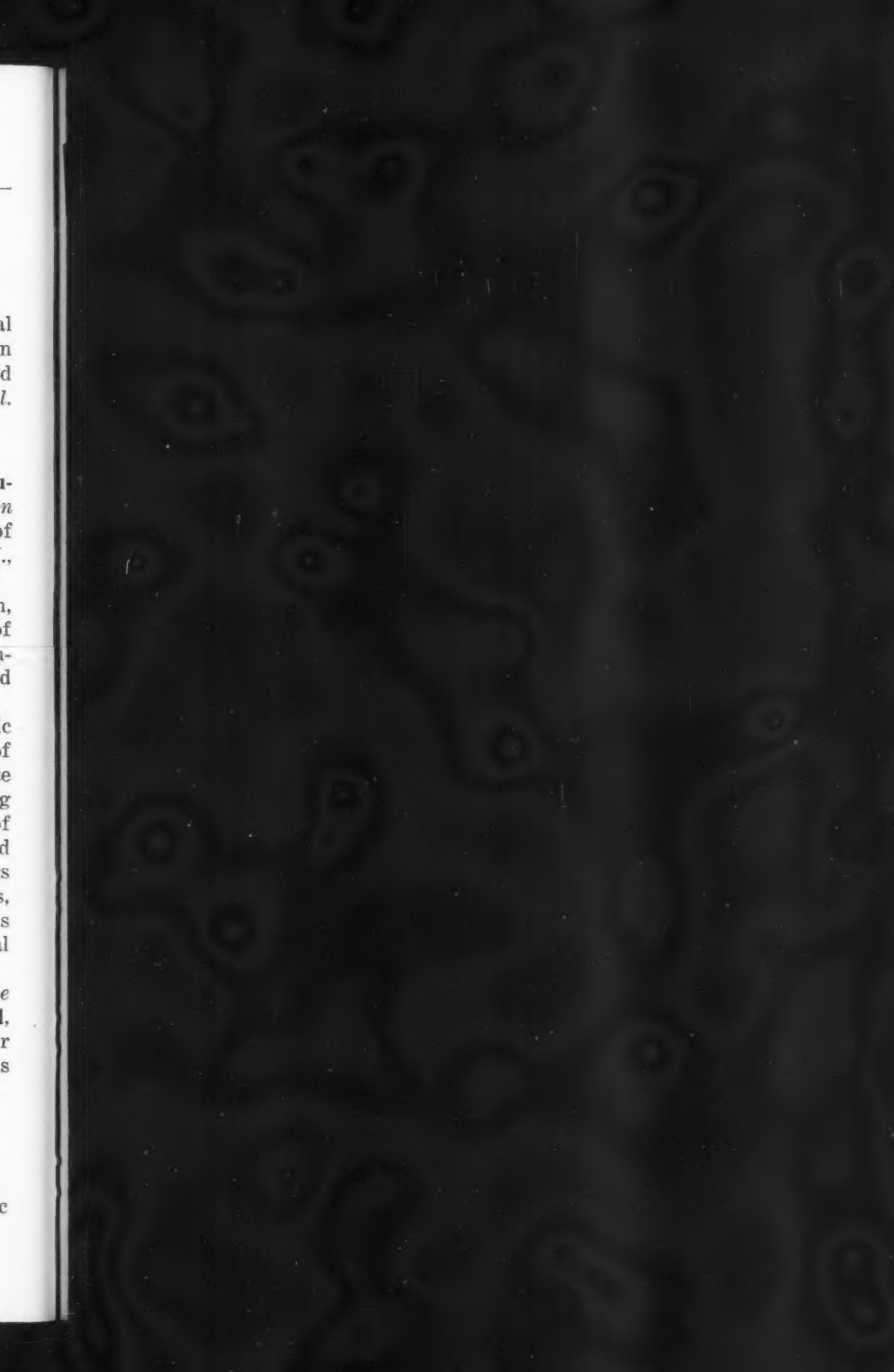
MEETING

American School Health Association and American Public Health Association at Cleveland, Ohio, in 1952.



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